Actemra® (tocilizumab) Referral Form

Patient Preferred Clinic (select one):

PATIENT INFORMATION

Referral Status: New Referral Updated Referral Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

NKDA Allergies: Weight (lbs/kg): Height:

ICD-10 code (required): ICD-10 description: Last Treatment Date: Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

CBC At each dose Every ______________________
CMP At each dose Every ______________________
CRP At each dose Every ______________________
OTHER

***Vivo Infusion will perform pregnancy screening prior to every infusion per Vivo policy*

PREMEDICATIONS

acetaminophen (Tylenol) 500 mg 650 mg 1000 mg PO
cetirizine (Zyrtec) 10mg PO
loratadine (Claritin) 10mg PO
diphenhydramine (Benadryl) 25 mg 50 mg PO IV
methylprednisolone (Solu-Medrol) 40mg 125mg IV
hydrocortisone (Solu-Cortef) 100mg IV
Other: ____
Dose: ________________ Route: _____________________

ACTEMRA THERAPY ADMINISTRATION

Dose will be rounded to the nearest vial size to minimize waste.

4mg/kg IV every 4 weeks with max dose of 800 mg

6mg/kg IV every 4 weeks with max dose of 600 mg **GCA ONLY**

8 mg/kg IV every 4 weeks with max dose of 800 mg

PJIA Indication:
Less than 30 kg: 10 mg/kg every 4 weeks
Greater than or equal to 30 kg: 8 mg/kg every 4 weeks

SJIA Indication:
Less than 30 kg: 12 mg/kg every 2 weeks
Greater than or equal to 30 kg: 8 mg/kg every 2 weeks

REQUIRED DOCUMENTATION

Patient Demographics
Insurance card/Information
Progress Notes supporting DX
Medication List and H&P
Hep B Surface Antigen (within 36 months)
TB results (within 6 months)
Comprehensive Metabolic Panel
Complete Blood Count

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted**

Provider Name (Print) **Provider Signature** **Date**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below **Have a Question? Call (720) 902-4111**

Colorado: 303-418-4679	Michigan: 833-957-2188	New York: 800-540-1852	Texas: 469-340-0044
Connecticut: 203-724-4838	Minnesota: 763-290-0903	Ohio: 216-400-0674	Virginia: 804-500-5941
Florida: 904-930-4211	Nevada: 702-489-5744	Oklahoma: 918-770-4421	Wisconsin: 414-600-5383
Massachusetts: 800-540-1852	New Jersey: 800-540-1852	Pennsylvania: 215-399-9244	